

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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Nursing Facility Provider Fee Invoicing Process

As of Thursday, April 9, 2009

The information enclosed in this packet is being sent in accordance with the provisions of Colorado House Bill 08-1114, which was signed into law by the Governor of Colorado in 2008. The law calls for the enactment of a new Medicaid reimbursement system for Medicaid recipients who reside in nursing homes classified as Class 1 nursing facilities by statute. Class 1 nursing facilities provide for general skilled nursing care to residents who require 24 hour care. The new Medicaid reimbursement system is funded via a provider fee assessed to all nursing facility providers which meet state licensing requirements, with certain exceptions as defined in the law. The law assesses the fee retroactively to July 1, 2008.

Below is a more detailed discussion of the new Medicaid reimbursement system and the provider fee. If applicable to your facility, invoices which cover the period from July 1, 2008 through June 30, 2009 are included in this mailing.

General questions and questions about the provider fee invoicing process, due dates and late penalties should be addressed to the Colorado Department of Health Care Policy & Financing Nursing Facility Provider Fee Accountant at 303-866-3820.

Questions regarding the calculation of the provider fee or the per diem rates determined as a result of the new Medicaid reimbursement system should be addressed to Diane Taylor, Nursing Facilities Section Manager, at 303-866-2336, or to Dick Gallagher, Nursing Facilities Section Auditor, at 303-866-2858.

Introduction

Starting May 1, 2009, The Department of Health Care Policy and Financing (The Department) will begin charging and collecting a provider fee on all Class 1 Nursing Facilities in the State of Colorado. The provider fee, created by HB 08-1114 and codified at C.R.S 25.5-5-203, provides a mechanism to increase Medicaid provider rates through a number of incentives while protecting general fund growth. Once collected, the provider fee will establish a cash fund that will be used to cover all costs associated with the following Medicaid expenses related to Nursing Facility rates:

- <u>Cognitive Performance Scale (CPS)</u> A supplemental add-on to the daily rate for those residents with severe cognitive dementia or acquired brain injury.
- <u>Preadmission Screening and Resident Review Assessment Tool (PASSR 2)</u> A supplemental add-on for those residents who have severe mental health conditions that are classified at Level 2 under this assessment tool.

- Pay For Performance A supplemental add-on to providers who add services that result in better care and higher quality of life for their residents.
- <u>Provider Fee Offset Payment</u> A supplemental add-on to offset the cost of paying the provider fee.
- <u>State Expenditure Growth Beyond 3 Percent</u> All growth in State General Fund expenditure beyond 3% of the prior year will be funded from the provider fee.
- <u>Administrative Cost</u> Costs incurred by the Department of Health Care Policy & Financing in order to administer the program.

This document provides information about the invoicing and collection process of the provider fee for the **State Fiscal Year 2008-2009 (FY 08-09)**, including:

- information about how the provider fee and interim rates for FY 08-09 have been determined;
- information about the retroactive invoicing process to cover claims for the period from July 2008 to April 2009; and
- information about the basic invoicing process for May and June 2009.

Interim Rates for Fiscal Year End 08-09

This section describes how we will transition from the previous rules and rate setting system to the new rules.

The Medical Services Board approved new Nursing Facility reimbursement rules at the April 10, 2009 meeting. The new rules are located at 10 CCR 2505-10 Volume 8.443 through Volume 8.443.17. Nursing facility rates effective on or after July 1, 2008 will be calculated according to the new rules. You may have already received final rates effective July 1, 2008 or later calculated in accordance with the previous rules. The new rules classify costs between the health care and administrative and general cost centers differently from the previous rules. Cost classifications will be revised to comply with the new rules for cost reports that determine the July 1, 2008 rate. Because the reclassification process is not complete, your July 1, 2008 interim rate is not a final rate. The reclassification process must be completed by June 30, 2009. Once completed, the Department will calculate final rates effective on or after July 1, 2008 in accordance with the new rules.

The new rules at 8.443.8.E state: "For the purposes of reimbursing a Medicaid-certified Class I nursing facility provider a per diem rate for the cost of its administrative and general services, the Department shall establish an annually readjusted schedule to pay each facility a reasonable price for the costs. The reasonable price shall be a percentage of the median per diem cost of administrative and general services as determined by an array of all nursing facility providers."

Once the reclassification adjustments for all providers are entered into the rate setting system, we will determine the administrative and general median per diem cost. A percentage of the median will then be used to determine the final administrative and general price effective July 1, 2008.

The July 1, 2008 interim rate will not include a per diem add-on for the PASRR II Specialized Program. Information for this program is not currently available. If you qualify, this add-on will be included in your final July 1, 2008 rate.

Retroactive Invoicing Procedure

This section describes the retroactive invoicing procedure to be used for the period from July 1, 2008 through April 30, 2009.

Initially, the Department will collect and reimburse the provider fee for the first ten months of FY 08-09. This retroactive period will be broken into three payment periods, and the Department will invoice the retroactive payments with a special invoicing process. This process has been designed to maximize provider cash flow while ensuring that all expenditures related to the provider fee in FY 08-09 are recorded during the 08-09 fiscal year.

Due to the size of the retroactive fee assessment, the Department will not collect the retroactive payment in one lump sum, but instead allow Nursing Facilities to make the payments over a two month period. The collection of the retroactive provider fee for the months of July 2008 through April 2009, and the subsequent mass adjustment of Medicaid claims for that period, will be split into three payment periods. For each payment period, the Department will invoice the fee and adjust the MMIS claims for one-third of the full retroactive payment.

Included with this document is the FY 08-09 provider fee invoice packet. A version of this packet has been provided to all Class 1 Nursing Facilities and their management companies. For individual Nursing Facilities, this packet includes an invoice for the three payment periods (which cover claims from July 1, 2008 to April 30, 2009), along with a separate invoice for May and a separate invoice for June. Each invoice lists the amount due for the current period or month, the covered period, and the date the payment must be received by the Department. The May and June invoices will also include a survey to collect monthly utilization information. An example of this utilization survey is provided later in this document.

Management companies have also been sent an FY 08-09 provider fee invoicing packet. The management company version of this packet includes a report of the interim rate and provider fee due for each of their associated facilities, along with a detailed report which lists each invoice for each facility. It is the responsibility of each Nursing Facility to coordinate their provider fee payment to the Department. The Department makes no stipulations about whether payment is provided by the management company or by the individual Nursing Facility.

Please refer to Attachment A for a flowchart of the retroactive invoicing process described below.

Period 1

• The Department will mass adjust all facility Period 1 claims on or about April 20, 2009, for a May 1, 2009 payment date. The Period 1 fee will be due to the Department on May 7, 2009.

To address potential cash flow issues for Nursing Facilities, the Department will mass adjust all Nursing Facility claims for Period 1 before collecting any retroactive fee payments. On **April 13, 2009**, the Department will mass adjust all Nursing Facility claims for the period **July 1, 2008 through October 31, 2008** using the new rate methodology established under HB 08-1114. On **May 1, 2009**, the Department will initiate the payment process for all Medicaid Nursing Facilities. The resulting Electronic Funds Transfer (EFT) payment or check will cover the difference between **the amount previously paid for Period 1 claims** and the new interim rate.

Each facility will then have until **May 7, 2009** to return the Period 1 provider fee payment to the Department.

Period 2

• The Department will mass adjust all facility Period 2 claims on or about May 22, 2009. Facilities that have not paid their full Period 1 fee by May 7, 2009, will be subject to an Accounts Receivable (A/R) transaction to cover the unpaid balance of Period 1 fee.

The Period 2 payment process will be similar to Period 1 in that the Department will mass adjust facility claims before collecting the Period 2 fee. The Department will mass adjust claims for all facilities that have paid their entire Period 1 fee, for the period **November 1, 2008 through January 31, 2009.** On May 22, 2009, the Department will initiate the payment process for all Medicaid Nursing Facilities.

For any Nursing Facility that has not paid their entire Period 1 fee by **May 7, 2009,** the Department will still mass adjust all Period 2 claims but will set up an accounts receivable transaction against the **mass adjustment** up to 100% on the mass adjustment. For these facilities, on **May 22, 2009** the Department will transfer funds equaling the Period 2 reimbursement minus any Period 1 fee not collected. If a facility's Period 1 fee is greater than their Period 2 reimbursement, the accounts receivable transaction will remain in effect at 25% per claim until the balance is paid.

Example 1: P2 Reimbursement > P1 Fee			
Period 1 fee =	\$ 6,500.00		
Period 2 reimbursement =	\$ 7,000.00		
Period 2 EFT =	\$ 500.00		
Remaining A/R on Account =	\$ 0.00		

Example 2: P2 Reimbursement < P1 Fee			
Period 1 fee =	\$	8,000.00	
Period 2 reimbursement =	\$	6,000.00	
Period 2 EFT =	\$	0.00	
Remaining A/R on Account =	\$	2,000.00	

The Period 2 fee will be due to the Department on May 29, 2009 for all Nursing Facilities regardless of payment of Period 1. If a facility is unable to pay their fee by this date, the Department will set up an accounts receivable on their Period 3 reimbursement. This option will be discussed in more detail in the next section.

Period 3

• The Department will collect Period 3 payment before any claims are adjusted. The fee will be due by June 5, 2009. On June 19, 2009, the Department will mass adjust all claims for Period 3.

The Period 3 payment will be different from the first two periods in that the Department will first collect the fee before mass adjusting any facility claims. The Department has determined that if

facilities follow the payment schedule as described for the previous two periods, most Medicaid facilities should not have cash flow concerns related to the retroactive payment for Period 3. On **June 5, 2009**, the Period 3 fee will be due to the Department. If a facility pays their entire Period 3 fee by **June 5, 2009**, the Department will mass adjust their claims for the Period **February 1, 2009 through April 30, 2009**. On **June 19, 2009**, the Department will transfer funds to a facility that has paid their entire Period 2 and Period 3 fee the difference between old **rate set July 1, 2008 and the new interim rate.**

For any facility that has not paid their entire Period 2 payment by **May 29, 2009** or Period 3 payment by **June 5, 2009**, the Department will mass adjust the Period 3 claims but will set up an accounts receivable up to 100% on the mass adjustment. On **June 19, 2009**, the Department will reimburse a facility the difference between the old **rate set July 1, 2008** and **the new interim rate** minus the Period 2 and/or Period 3 fee not collected by the Department. If a facility has a fee greater than the reimbursement, the Department will set up an accounts receivable transaction equal to 25% for all facility claims submitted in the MMIS in the month of July.

Example 3			
Period 2 fee =	\$5,000.00		
Period 3 Fee =	\$5,000.00		
Period 3 reimbursement =	\$6,000.00		
Period 2 EFT =	\$0.00		
A/R on July claims =	\$4,000.00		

Non-Medicaid Providers and the Retroactive Payment Process

Non-Medicaid providers are encouraged to follow the timelines as described above. While it is critical that the Department record the receipt of provider fee payments prior to June 30, 2009, the Department is aware that funds may not be available to meet the Medicaid provider deadlines. Therefore, the Department will not assess any penalties or make collections referrals for missed deadlines until after the start of the next fiscal year (July 1, 2009). Non-Medicaid providers can pay at their own pace, as long as all fees are received by the Department on or before June 30, 2009. All Non-Medicaid provider accounts will be evaluated after July 1st for possible collections referrals or penalties yet to be determined.

Basic Invoicing Procedure

This section describes the basic invoicing procedure to be used beginning with the May 2009 provider fee payment.

- May and June provider fee payments will not be included in the retroactive payment periods. Instead, May's fee will be due on May 29, 2009 and June's fee will be due on June 26, 2009. If a payment is late, a facility will be assessed a late payment penalty.
- May and June provider fee invoices will include a utilization survey to be included with the payment to the Department. The purpose of the survey is to assist the Department in determining the provider fee for future fiscal years.

Because the May and June provider fee amounts are not included within the retroactive period, the procedures for both the collection and the reimbursement will be different from the retroactive invoicing procedure discussed previously in this document.

Starting **April 14, 2009**, the Department will load a new interim rate into the MMIS with an effective date of July 1, 2008. New claims submitted after this date will be reimbursed using the new rate. This new rate will be in place for all claims submitted during the FY 08-09 fiscal year.

Both May and June provider fee payments will be due at the end of each month. The May payment will be due by **May 29, 2009** and the June payment will be due by **June 26, 2009**. If the Department does not receive either payment by its respective due date, the Nursing Facility will receive one of the late payment penalties listed below.

- For Medicaid providers, 1% of the monthly fee assessment will be added to the next month's provider fee invoice for each day that the payment is late to the Department, up to a maximum of 10%. If the facility does not pay the fee within the 10 day maximum, the Department will set up an accounts receivable transaction against the Nursing Facility's account in the MMIS. The overdue provider fee assessment, as well as the 10% administrative penalty, will be subtracted from that facility's next claims payment.
- For facilities that do not submit claims to Medicaid, 1% of the monthly fee assessment will be added to the next month's provider fee invoice for each day that the payment is late to the Department, up to a maximum of 10%. Invoices in excess of two months late will be referred to collections.

As discussed previously in this document, the May and June invoices will include a utilization survey to be completed by all Nursing Facilities for each month. The survey will ask each facility to list total patient days, Medicare patient days, and Medicaid patient days. In order to achieve a reliable average for calculating the Nursing Facility provider fee in future fiscal years, the survey will ask for day totals for the month prior to the invoice month, for the current invoice month, and for the next invoice month. The Department will use this information to create a rolling average of non-Medicare days to assist in the calculation of the provider fee for the next fiscal year. The survey should be completed using the best information available at the time of completing the invoice. Facilities that are not Medicaid or Medicare certified will be required to complete the applicable fields only. Examples of two months of the utilization survey are provided below:

Example Utilization Survey for July 1 Invoice

Utilization	Survey	Total Patient Days	Medicaid Patient Days	Medicare Patient Days
Previous Month	June	2753	197	2069
Current month	July	2760	205	2075
Next Month	August	2765	203	2078

Example Utilization Survey for August 1 Invoice

Utilization	Survey	Total Patient days	Medicaid Patient Days	Medicare Patient Days
Previous Month	July	2760	202	2076
Current month	August	2764	203	2075
Next Month	September	2766	208	2073

General Questions, Dispute Resolution, and Other Concerns

General questions and questions about the provider fee invoicing process, due dates and late penalties should be addressed to the Colorado Department of Health Care Policy & Financing Nursing Facility Provider Fee Accountant at 303-866-3820.

Questions regarding the calculation of the provider fee or the per diem rates determined as a result of the new Medicaid reimbursement system should be addressed to Diane Taylor, Nursing Facilities Section Manager, at 303-866-2336, or to Dick Gallagher, Nursing Facilities Section Auditor, at 303-866-2858.

The Colorado Health Care Association is hosting a free webinar online conference to discuss the details of this packet. The webinar will be hosted by Department staff representing the Rates Section and Nursing Facilities section. A detailed invitation, including sign-up instructions, is included with this packet.